Time	PeakFlow L/min	Timing	Method
10:21 AM	270		

Measured By

Time	Measured by
10:21 AM	Andrea K. Fulton, MA

Physical Exam

Exam	Findings	Details
General Exam	Comments	Pt is wheezing less than used to
Constitutional	Normal	Well developed.
Eyes	Normal	Conjunctiva - Right: Normal, Left: Normal.
Ears	Normal	Inspection - Right: Normal, Left: Normal. Hearing - Right: Normal, Left: Normal.
Nose/Mouth/Throat	Normal	Lips/teeth/gums - Normal. Oropharynx - Normal.
Neck Exam	Normal	Inspection - Normal. Palpation - Normal.
Respiratory	*	Auscultation - Location: posterior, Findings: wheezing.
Respiratory	Normal	Inspection - Normal. Effort - Normal.
Cardiovascular	Normal	Regular rhythm. No murmurs, gallops, or rubs.
Vascular	Normal	Pulses - Dorsalis pedis: Normal. Capillary refill - Less than 2 seconds.
Abdomen	Normal	Inspection - Normal.
Musculoskeletal	Normal	Visual overview of all four extremities is normal.
Extremity	Normal	No edema.
Neurological	Normal	Memory - Normal. Cranial nerves - Cranial nerves II through XII grossly intact.
Psychiatric	Normal	Orientation - Oriented to time, place, person & situation. Appropriate mood and affect.

Assessment/Plan

#	Detail Type	Description
1.	Assessment	Asthma (493.90).
	Impression	Mild intermittent. Pt is stable with current medications. Estimate peak flow: 627 L/min, education about inhaler use, triggers, and disease process d/w pt..
2.	Assessment	Hypercholesterolaemia (272.0).
	Impression	Pt wants to get off Zocor 10 mg daily. Pt thinks that he can change life style, and he does not want to take it any more. Risk of not taking medication d/w pt..
3.	Assessment	GERD (530.81).
	Impression	Pt wants to get off Pepcid. he wants to minimize the medications he take, and he does not want it any more..

Medications *(Added, Continued or Stopped today)*

Start Date	Medication	Directions	PRN Status	PRN Reason	Instruction	Stop Date
10/14/2019	albuterol sulfate 2.5 mg/3 mL (0.083 %) solution for	inhale 3 milliliter by nebulization route 2 times every day, as needed	N		do not send	04/10/2020

10/14/2019	nebulization ipratropium bromide 0.02 % solution for inhalation	inhale 2.5 milliliter by inhalation route twice daily as needed, MIX WITH ALBUTEROL	N	do not send	04/10/2020
10/14/2019	Xopenex HFA 45 mcg/actuation aerosol inhaler	inhale 2 puff by inhalation route every 6 hours, as needed.	N		04/10/2020

Provider:
Savino, Yoko 10/14/2019 10:34 AM
Document generated by: Yoko Savino, MD 10/14/2019 10:34 AM

Indiana Government Center South
302 W. Washington Street
Indianapolis, IN 46204

State of Indiana
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Indiana Government Center South
302 W. Washington Street
Indianapolis, IN 46204

Facility: CIC

PATIENT: JONATHAN RICHARDSON
DATE OF BIRTH: [redacted]
DOC#: 127630
DATE: 10/12/2019 12:20 PM
VISIT TYPE: Nurse Visit

Established patient

PROBLEM LIST:

Problem Description	Onset Date	Chronic	Clinical Status	Notes
Severe recurrent major depression with psychotic features	01/17/2011	N		
Gastroesophageal reflux disease	02/19/2015	Y		Mapped from KBM Chronic Conditions table on 05/09/2016 by the ICD9 to SNOMED Bulk Mapping Utility. The mapped diagnosis code was Esophageal reflux, 530.81, added by Paul A. Talbot, MD, with responsible provider Paul A. Talbot MD. Onset date 02/19/2015.
Borderline personality disorder	05/04/2010	Y		Mapped from KBM Chronic Conditions table on 05/09/2016 by the ICD9 to SNOMED Bulk Mapping Utility. The mapped diagnosis code was Borderline personality disorder, 301.83, added by Darla Hinshaw, MD, with responsible provider . Onset date 05/04/2010; Axis II.

Problem List (not yet mapped to SNOMED-CT®):

Problem Description	Onset Date	Notes
Asthma	03/19/2007	
Polysubstance Dependence	01/17/2011	
major depression in remission	01/17/2011	
Nonspecific reaction to tuberculin skin test witho	02/01/2011	
Epilepsy	06/11/2015	

Allergies

Ingredient	Reaction	Medication Name	Comment
PENICILLINS	Rash		
IBUPROFEN	Rash		
CEFTRIAXONE SODIUM	SOB, chest pressure, rash	ROCEPHIN	Pt was given 0.5mg Epi x1

and NS IV w/
good results

Suicide Risk Screening

Medications *(Added, Continued or Stopped this visit)*

Start Date	Medication	Directions	PRN Status	PRN Reason	Instruction	Stop Date
06/06/2019	albuterol sulfate 2.5 mg/3 mL (0.083 %) solution for nebulization	inhale 3 milliliter by nebulization route 2 times every day, as needed	N		do not send	12/02/2019
06/06/2019	ipratropium bromide 0.02 % solution for inhalation	inhale 2.5 milliliter by inhalation route twice daily as needed, MIX WITH ALBUTEROL	N		do not send	12/02/2019
07/16/2019	Pepcid 20 mg tablet	take 1 tablet by oral route 2 times every day	N			11/12/2019
07/16/2019	Xopenex HFA 45 mcg/actuation aerosol inhaler	inhale 2 puff by inhalation route every 6 hours, as needed.	N			01/11/2020
07/16/2019	Zocor 10 mg tablet	take 1 tablet by oral route every day in the evening	N			01/11/2020

TB Screening: PPD Placed

TST:

Placed	Read	Result	Side	Site
10/12/2019			left	LA

Provider:
Burdine, Vicki E 10/12/2019 12:20 PM
Document generated by: Jodean Ayres, RN 10/12/2019 12:20 PM

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Facility: CIC

PATIENT:	JONATHAN RICHARDSON
DATE OF BIRTH:	[redacted]
DOC #:	127630
DATE:	10/07/2019 7:56 PM
VISIT TYPE:	Chart Update

Nurse Visit

Reason for visit: CC lab draw

Nurse Protocols:
Review/Comments
Patient smokes 20.00 packs a year

Medications

Medication	Sig	PRN Status	PRN Reason	Comment
albuterol sulfate 2.5 mg/3 mL (0.083 %) solution for nebulization	inhale 3 milliliter by nebulization route 2 times every day, as needed	N		
ipratropium bromide 0.02 % solution for inhalation	inhale 2.5 milliliter by inhalation route twice daily as needed, MIX WITH ALBUTEROL	N		
Pepcid 20 mg tablet	take 1 tablet by oral route 2 times every day	N		
Xopenex HFA 45 mcg/actuation aerosol inhaler	inhale 2 puff by inhalation route every 6 hours, as needed.	N		
Zocor 10 mg tablet	take 1 tablet by oral route every day in the evening	N		

Orders

Status	Order	Timeframe	Frequency	Duration	Stop Date
ordered	CBC WITH DIFF				
ordered	COMPREHENSIVE METABOLIC PANEL				
ordered	LIPID (CARDIAC) PANEL(INCL CHOLESTEROL, TRIG, HDL, LDL)				

Document generated by: Tina Collins, RN 10/07/2019 07:56 PM

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Facility: CIC

PATIENT: JONATHAN RICHARDSON
DATE OF BIRTH: [redacted]
DOC #: 127630
DATE: 10/05/2019 5:01 PM
VISIT TYPE: Nurse Visit

Nurse Visit

Reason for visit: PRN breathing treatment

Vital Signs

Blood Pressure

Time	BP mm/Hg	Position	Side	Site	Method	Cuff Size
5:03 PM					automatic	

Temperature/Pulse/Respiration

Time	Temp F	Temp C	Temp Site	Pulse/min	Pattern	Resp/ min
5:03 PM				103	regular	
5:02 PM				79		

Pulse Oximetry/FIO2

Time	Pulse Ox (Rest %)	Pulse Ox (Amb %)	O2 Sat	O2 L/Min	Timing	FiO2 %	L/min	Delivery Method	Finger Probe
5:03 PM	98		RA		Post-tx				
5:02 PM	99		RA		Pre-tx				

Peak Flow

Time	PeakFlow L/min	Timing	Method
5:03 PM	250	Post-tx	hand held
5:02 PM	230	Pre-tx	hand held

Comments

Time	Comments
5:03 PM	230, 250, 250.
5:02 PM	200, 180, 230

Measured By

Time	Measured by
5:03 PM	Tamera L. Smith, RN
5:02 PM	Tamera L. Smith, RN

Nurse Protocols:

RESPIRATORY

Subjective:
Date of Onset: 10/05/2019
Previous history? Yes. Comments: asthma
Previous treatment effective? Yes.

Objective:
Lungs
Left lung:
Clear to auscultation? No.
Wheezes? Yes.

Right lung
Clear to auscultation? No.
Wheezes? Yes.

Assessment:
Alteration in health maintenance related to: asthma, .
.

Review/Comments
Patient smokes 20.00 packs a year

Medications

Medication	Sig	PRN Status	PRN Reason	Comment
albuterol sulfate 2.5 mg/3 mL (0.083 %) solution for nebulization	inhale 3 milliliter by nebulization route 2 times every day, as needed	N		
ipratropium bromide 0.02 % solution for inhalation	inhale 2.5 milliliter by inhalation route twice daily as needed, MIX WITH ALBUTEROL	N		
Pepcid 20 mg tablet	take 1 tablet by oral route 2 times every day	N		
Xopenex HFA 45 mcg/actuation aerosol inhaler	inhale 2 puff by inhalation route every 6 hours, as needed.	N		
Zocor 10 mg tablet	take 1 tablet by oral route every day in the evening	N		

Orders

Status	Order	Timeframe	Frequency	Duration	Stop Date
completed	Medication allergies reviewed, other contraindications and pregnancy ruled out prior to treatment				
completed	Sick call if signs and symptoms of infection develop or symptoms do not subside				
completed	Patient education provided.				

General Comments

Pt presents to medical from kitchen stating his chest feels tight with breathing. Breathing tx administered. Pt states he feels better after treatment. Pt may return to medical as needed.

Education	Date Provided	Provided By
Medication allergies reviewed, other contraindications and pregnancy ruled out prior to treatment	10/05/2019	Tamera L. Smith, RN
Patient education provided.	10/05/2019	Tamera L. Smith, RN

Document generated by: Tamera L. Smith, RN 10/05/2019 05:06 PM

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Facility: CIC

PATIENT: JONATHAN RICHARDSON
DATE OF BIRTH: [redacted]
DOC#: 127630
DATE: 10/01/2019 01:35 PM
VISIT TYPE: Provider Visit

Established patient

History of Present Illness:

1. TG evaluation sheet

PROBLEM LIST:

Problem Description	Onset Date	Chronic	Clinical Status	Notes
Severe recurrent major depression with psychotic features	01/17/2011	N		
Gastroesophageal reflux disease	02/19/2015	Y		Mapped from KBM Chronic Conditions table on 05/09/2016 by the ICD9 to SNOMED Bulk Mapping Utility. The mapped diagnosis code was Esophageal reflux, 530.81, added by Paul A. Talbot, MD, with responsible provider Paul A. Talbot MD. Onset date 02/19/2015.
Borderline personality disorder	05/04/2010	Y		Mapped from KBM Chronic Conditions table on 05/09/2016 by the ICD9 to SNOMED Bulk Mapping Utility. The mapped diagnosis code was Borderline personality disorder, 301.83, added by Darla Hinshaw, MD, with responsible provider . Onset date 05/04/2010; Axis II.

Problem List (not yet mapped to SNOMED-CT®):

Problem Description	Onset Date	Notes
Asthma	03/19/2007	
Polysubstance Dependence	01/17/2011	
major depression in remission	01/17/2011	
Nonspecific reaction to tuberculin skin test witho	02/01/2011	
Epilepsy	06/11/2015	

Allergies

Ingredient	Reaction	Medication Name	Comment
PENICILLINS	Rash		
IBUPROFEN	Rash		
CEFTRIAXONE SODIUM	SOB, chest pressure, rash	ROCEPHIN	Pt was given 0.5mg Epi x1 and NS IV w/ good results
EGG			

Review of Systems

System	Neg/Pos	Details
Neuro	Negative	Loss of consciousness.
Psych	Negative	Difficulty concentrating, inappropriate interaction, inconsolable and psychiatric symptoms.
Psych	Comments	Pt denies suicidal or homocidal ideation.

Vital Signs

Height

Time	ft	in	cm	Last Measured	Height Position
1:35 PM	5.0	11.0	0.0	02/08/2014	0

Weight/BSA/BMI

Time	lb	oz	kg	Context	BMI kg/m2	BSA m2
1:35 PM	200.0		90.718	dressed with shoes	27.89	

Blood Pressure

Time	BP mm/Hg	Position	Side	Site	Method	Cuff Size
1:35 PM	1010/70	sitting	right	arm	manual	adult

Temperature/Pulse/Respiration

Time	Temp F	Temp C	Temp Site	Pulse/min	Pattern	Resp/ min
1:35 PM	98.70	37.1	oral	78	regular	16

Pulse Oximetry/FIO2

Time	Pulse Ox (Rest %)	Pulse Ox (Amb %)	O2 Sat	O2 L/Min	Timing	FiO2 %	L/min	Delivery Method	Finger Probe
1:35 PM	97		RA			21			

Measured By

Time	Measured by
1:35 PM	Andrea K. Fulton, MA

Physical Exam

Exam	Findings	Details
Constitutional	Normal	Well developed.
Eyes	Normal	Conjunctiva - Right: Normal, Left: Normal.
Ears	Normal	Inspection - Right: Normal, Left: Normal. Hearing - Right: Normal, Left: Normal.
Respiratory	Normal	Effort - Normal.
Vascular	Normal	Pulses - Dorsalis pedis: Normal. Capillary refill - Less than 2 seconds.

Musculoskeletal	Normal	Visual overview of all four extremities is normal.
Extremity	Normal	No edema.
Neurological	Normal	Memory - Normal. Cranial nerves - Cranial nerves II through XII grossly intact.
Psychiatric	Normal	Orientation - Oriented to time, place, person & situation. Appropriate mood and affect.

Suicide Risk Screening

Assessment/Plan

#	Detail Type	Description
1.	Assessment	Exam (V72.85).
	Impression	Transgender evaluation sheet filled out. From today's brief evaluation, it is not clear if the offender is having gender dysphoria or not. Pt does not have suicidal/homocidal ideation..

Medications *(Added, Continued or Stopped this visit)*

Start Date	Medication	Directions	PRN Status	PRN Reason	Instruction	Stop Date
06/06/2019	albuterol sulfate 2.5 mg/3 mL (0.083 %) solution for nebulization	inhale 3 milliliter by nebulization route 2 times every day, as needed	N		do not send	12/02/2019
06/06/2019	ipratropium bromide 0.02 % solution for inhalation	inhale 2.5 milliliter by inhalation route twice daily as needed, MIX WITH ALBUTEROL	N		do not send	12/02/2019
07/16/2019	Pepcid 20 mg tablet	take 1 tablet by oral route 2 times every day	N			11/12/2019
07/16/2019	Xopenex HFA 45 mcg/actuation aerosol inhaler	inhale 2 puff by inhalation route every 6 hours, as needed.	N			01/11/2020
07/16/2019	Zocor 10 mg tablet	take 1 tablet by oral route every day in the evening	N			01/11/2020

Provider:
Savino, Yoko 10/01/2019 4:24 PM
Document generated by: Yoko Savino, MD 10/01/2019 04:24 PM

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Indiana Government Center South
302 W. Washington Street
Indianapolis, IN 46204

Facility: CIC

PATIENT: JONATHAN RICHARDSON
DATE OF BIRTH: [redacted]
DOC#: 127630
DATE: 09/26/2019 2:10 PM
VISIT TYPE: Onsite Consult

INDIVIDUALIZED ACTION PLAN

Program name: Outpatient
Admission date: 06/09/2016
Effective date of initial IAP:
Next review date: 03/26/2020

GOALS, OBJECTIVES AND INTERVENTIONS

Goal 3: Alleviate depressive symptoms (continued)

Target date: 03/26/2020
Adjusted target date: 09/07/2017 (Adjusted as per IAP review dated 05/01/2018)

Assessed need: Depression

Individual's strength/skills: {local.txt_stengths}

Potential barriers: {local.txt_barriers}

- Objective 1: Identifies negative thinking supporting depression (continued)
Start date: 06/30/2012
Target date: 03/26/2020
Adjusted target date: 09/07/2017 (Adjusted as per IAP review dated 05/01/2018)

-- Intervention 1: Individual Therapy
Frequency: q 90 days Type of provider: MHP

- Objective 2: Verbalizes increased feelings of self worth (continued)
Start date: 06/30/2012
Target date: 03/26/2020
Adjusted target date: 09/07/2017 (Adjusted as per IAP review dated 03/07/2017)

-- Intervention 2: Individual Therapy
Frequency: q 90 days Type of provider: MHP

Goal 4: Determine whether the offender meets criteria for gender dysphoria / determine appropriate treatment (continued)

Start date: 07/22/2019
Target date: 03/26/2020

Assessed need: Evaluation for gender dysphoria

Individual's strength/skills: {local.txt_stengths}

Potential barriers: {local.txt_barriers}

- Objective 1: Gather history and report of past and present symptoms that may support a diagnosis of gender dysphoria (continued)
Start date: 07/22/2019
Target date: 03/26/2020
Adjusted target date: (Adjusted as per IAP review dated 05/01/2018)

-- Intervention 1: Gender Dysphoria Evaluation and, if appropriate, staffing with multidisciplinary team to determine whether a diagnosis of gender dysphoria will be made.
Frequency: monthly Type of provider: Psychologist

TRANSITION/DISCHARGE CRITERIA

Individual has participated in the development of this plan:
Yes

Others participated in the development of this plan:
No

SIGNATURES

Staff: Signed by Richard J. Gale, PsyD, HSPP on 09/27/2019

Document generated by: Richard J. Gale, PsyD 09/27/2019 11:03 AM

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Indiana Government Center South
302 W. Washington Street
Indianapolis, IN 46204

Facility: CIC

PATIENT:	JONATHAN RICHARDSON
DATE OF BIRTH:	[redacted]
DOC #:	127630
DATE:	09/26/2019 2:10 PM
HISTORIAN:	self
VISIT TYPE:	Onsite Consult

Individual Counsel/Psych Prog Note

General

Program Name: Outpatient

Start time: 2:10 PM

End time: 00 hours, 45 minutes

Duration: 00 hours, 45 minutes

Individuals Present/Support Resources

Contact type:
Onsite
Individual present.

MENTAL STATUS EXAM
GENERAL OBSERVATIONS:
Generally normal
Appearance:Within normal limits
Build/Stature: Within normal limits
Posture: Within normal limits
Eye Contact: Average
Activity: Within normal limits
Attitude toward examiner: Cooperative
Attitude toward parent/guardian: Not Applicable
Separation (for children/adolescent): Not applicable

MENTAL STATUS:
Unremarkable
Mood: Euthymic
Affect: Full

Speech: Clear
Thought process: Logical
Perception: WNL
Hallucination: Denied None evidenced
Thought content: Within normal limits
Delusions: None Reported
Cognition: Within normal limits
Intelligence estimate: Average
Insight: Within normal limits
Judgment: Within normal limits

Subjective Information

Individual's report of progress towards goals/objectives since last session:
Ofd. seen in psychologist's office for regularly scheduled follow-up visit and ongoing assessment for appropriateness of gender dysphoria diagnosis. Ofd. identifies as a transgender woman and prefers feminine pronouns be used. She denied any new concerns or symptoms and inquired about the ongoing process of assessment for the appropriateness of diagnosis and treatment with hormone therapy. Denies SI/HI.

New issues/stressors/extraordinary events presented today: None reported

Explanation: Offender points to being off psychotropic medication for over 8 years as evidence that she is relatively psychologically stable, and that the gender dysphoria she reports is not a symptom of some other unmanaged mental illness.

Goals, Objectives, and Interventions Addressed Today

Goal Today	Objective Today
Determine whether the offender meets criteria for gender dysphoria / determine appropriate treatment	Gather history and report of past and present symptoms that may support a diagnosis of gender dysphoria

Interventions/Methods Provided:
Psychologist explored with offender the ways in which she believes her depression, history of self-harm, and other psychological concerns have actually been related to gender dysphoria concerns all along. Discussed reasons that this has only recently become something she is willing to talk about due to the recent IDOC policy regarding transgender offenders. Processed offender's thoughts regarding what will change as a result of being able to live more openly as a woman, both positive changes and negative. Discussed offender's discomfort with her male genitals and desire to be rid of them.
Response to Interventions/Progress Toward Goals and Objectives:
Ofd. reports making efforts to start to come out to people and to more openly express feminine mannerisms and speech patterns.

Current Assessment

Individual's progress: Some progress

Assessment:
Anxiety is not significant. Cognitive issues are not significant. Substance abuse/dependence is not significant. Depression is not significant. Impulse control is not significant. Psychotic symptoms are not significant. Suicidality is not significant. Mania/manic behavior is not significant. Patient is responding to treatment plan. The patient is compliant with the treatment plan. The patient is cooperative and communicative.

Risk Assessment

SAFETY MANAGEMENT PLAN

No currently expressed suicidal or homicidal ideation or intent. No current need for safety plan.

Assessment/Diagnosis

AXIS IV

Severity: Moderate

Problem Type	No/Yes	Description
Primary Support Group	Yes	Very little external support
Social environment	Yes	Difficulty Trusting Others - suspicious - isolates
Legal system/crime	Yes	Incarcerated

AXIS V

Current GAF: 68

Date: 09/26/2019.

Highest GAF: 68

Date: 08/16/2019.

Plan and Additional Information

Date	Order Description
10/17/2019	MHP follow-up for Ind Tx

SIGNATURES

Staff: Signed by Richard J. Gale, PsyD, HSPP on 09/27/2019

Behavioral Health Billing

Start time:	2:10 PM
End time:	2:55 PM
Duration:	00 hours, 45 minutes
Modifier:	N/A

Document generated by: Richard J. Gale, PsyD 09/27/2019 11:01 AM

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Indianapolis, IN 46204

Facility: CIC

PATIENT:	JONATHAN RICHARDSON
DATE OF BIRTH:	[redacted]
DOC #:	127630
DATE:	09/11/2019 11:13 AM
HISTORIAN:	self
VISIT TYPE:	Onsite Consult

Individual Counsel/Psych Prog Note

General

Program Name: Outpatient

Start time: 10:30 AM

End time: 00 hours, 30 minutes

Duration: 00 hours, 30 minutes

Individuals Present/Support Resources

Contact type:
Onsite
Individual present.

MENTAL STATUS EXAM
GENERAL OBSERVATIONS:
Generally normal
Appearance:Within normal limits
Build/Stature: Within normal limits
Posture: Within normal limits
Eye Contact: Average
Activity: Within normal limits
Attitude toward examiner: Cooperative
Attitude toward parent/guardian: Not Applicable
Separation (for children/adolescent): Not applicable

MENTAL STATUS:
Unremarkable
Mood: Euthymic
Affect: Full

Speech: Clear
Thought process: Logical
Perception: WNL
Hallucination: Denied None evidenced
Thought content: Within normal limits
Delusions: None Reported
Cognition: Within normal limits
Intelligence estimate: Average
Insight: Within normal limits
Judgment: Within normal limits

Subjective Information

Individual's report of progress towards goals/objectives since last session:
Ofd. reports identifying as a transgender female named Autumn and prefers to be referred to by feminine pronouns. She says that overall things are going ok right now. She reports having "come out" to several other offenders as transgender and experiencing more acceptance, or at least indifference, than rejection or hostility. No other concerns were brought up today other than wondering how the process of pursuing gender dysphoria diagnosis and hormone treatment will proceed.

New issues/stressors/extraordinary events presented today: None reported

Goals, Objectives, and Interventions Addressed Today

Goal Today	Objective Today
Determine whether the offender meets criteria for gender dysphoria / determine appropriate treatment	Gather history and report of past and present symptoms that may support a diagnosis of gender dysphoria

Interventions/Methods Provided:
Psychologist provided empathic listening, validation of the offender's emotions, and exploration of the emotional impacts of "coming out" and taking steps to start living as ofd's identified gender. Explored for other emotional, behavioral, or functional concerns. Agreed to continue to meet and pursue the offender's desire to receive hormone therapy.
Response to Interventions/Progress Toward Goals and Objectives:
Stable, mood somewhat improved.

Current Assessment

Individual's progress: Some progress

Assessment:
Anxiety is not significant. Cognitive issues are not significant. Substance abuse/dependence is not significant. Depression is improved. Impulse control is not significant. Psychotic symptoms are not significant. Suicidality is not significant. Mania/manic behavior is not significant. Patient is responding to treatment plan. The patient is compliant with the treatment plan. The patient is cooperative and communicative.

Risk Assessment

SAFETY MANAGEMENT PLAN
No currently expressed suicidal or homicidal ideation or intent. No current need for safety plan.

Assessment/Diagnosis

AXIS IV

Severity: Moderate

Problem Type	No/Yes	Description
Primary Support Group	Yes	Very little external support
Social environment	Yes	Difficulty Trusting Others - suspicious - isolates
Legal system/crime	Yes	Incarcerated

AXIS V
Current GAF: 68
Date: 09/11/2019.

Highest GAF: 68
Date: 08/16/2019.

Plan and Additional Information

Date	Order Description
09/27/2019	MHP follow-up for Ind Tx

SIGNATURES

Staff: Signed by Richard J. Gale, PsyD, HSPP on 09/11/2019

Behavioral Health Billing

Start time: 10:30 AM
End time: 11:00 AM
Duration: 00 hours, 30 minutes
Modifier: N/A

Document generated by: Richard J. Gale, PsyD 09/11/2019 05:15 PM

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State of Indiana
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Indiana Government Center South
302 W. Washington Street
Indianapolis, IN 46204

Facility: CIC

PATIENT:	JONATHAN RICHARDSON
DATE OF BIRTH:	[redacted]
DOC #:	127630
DATE:	08/26/2019 5:49 PM
HISTORIAN:	self
VISIT TYPE:	Onsite Consult

Individual Counsel/Psych Prog Note

General

Program Name: Outpatient

Start time: 3:15 PM

End time: 00 hours, 50 minutes

Duration: 00 hours, 50 minutes

Individuals Present/Support Resources

Contact type:
Onsite
Individual present.

MENTAL STATUS EXAM
GENERAL OBSERVATIONS:
Generally normal
Appearance:Within normal limits
Build/Stature: Within normal limits
Posture: Within normal limits
Eye Contact: Average
Activity: Within normal limits
Attitude toward examiner: Cooperative
Attitude toward parent/guardian: Not Applicable
Separation (for children/adolescent): Not applicable

MENTAL STATUS:
Unremarkable
Mood: Euthymic
Affect: Full

Speech: Clear
Thought process: Logical
Perception: WNL
Hallucination: Denied None evidenced
Thought content: Within normal limits
Delusions: None Reported
Cognition: Within normal limits
Intelligence estimate: Average
Insight: Within normal limits
Judgment: Within normal limits

Subjective Information

Individual's report of progress towards goals/objectives since last session:
Ofd. seen for scheduled follow-up therapy. Start of session delayed by crisis, but ofd. was very understanding of the delay. Continued with assessment of criteria for gender dysphoria and desire to start hormone therapy. Ofd. denied any other new concerns.

New issues/stressors/extraordinary events presented today: None reported

Goals, Objectives, and Interventions Addressed Today

Goal Today	Objective Today
Determine whether the offender meets criteria for gender dysphoria / determine appropriate treatment	Gather history and report of past and present symptoms that may support a diagnosis of gender dysphoria

Interventions/Methods Provided:
Psychologist utilized the gender dysphoria evaluation protocol provided by Wexford regional leadership and completed the discussion questions with the offender. Will compile ofd's responses/history into a summary report and present to regional leadership to collaborate with them on whether this offender meets criteria for a diagnosis of gender dysphoria.
Response to Interventions/Progress Toward Goals and Objectives:
Stable, open, gaining comfort with this process and with talking about being transgender.

Current Assessment

Individual's progress: Some progress

Assessment:
Anxiety is significant and improved. Cognitive issues are not significant. Substance abuse/dependence is not significant. Depression is significant and improved. Impulse control is not significant. Psychotic symptoms are not significant. Suicidality is not significant. Mania/manic behavior is not significant. Patient is responding to treatment plan. The patient is compliant with the treatment plan. The patient is cooperative and communicative.

Risk Assessment

CURRENT ENCOUNTER

Risk Assessments
Patient denies suicidal ideation, plan, intent, and/or attempt.
Patient denies property damage ideation, plan, intent, and/or attempt.
Patient denies homicidal ideation, plan, intent, and/or attempt.

RISK ASSESSMENT HISTORY

Risk	Current	Past	Documented	Event Date	Approximate Date	Ideation	Plan	Intent	Scale
Suicide	Denies		08/26/2019	08/26/2019	No				
Property	Denies		08/26/2019	08/26/2019	No				
Homicide	Denies		08/26/2019	08/26/2019	No				

Attempt	Planned/ Impulsive	Drug/Alcohol Influenced	Medically Treated	Plan Attempt Description

SAFETY MANAGEMENT PLAN

No currently expressed suicidal or homicidal ideation or intent. No current need for safety plan.

Assessment/Diagnosis

AXIS IV

Severity: Moderate

Problem Type	No/Yes	Description
Primary Support Group	Yes	Very little external support
Social environment	Yes	Difficulty Trusting Others - suspicious - isolates
Legal system/crime	Yes	Incarcerated

AXIS V

Current GAF: 68

Date: 08/26/2019.

Highest GAF: 68

Date: 08/16/2019.

Plan and Additional Information

Date	Order Description
09/09/2019	MHP follow-up for Ind Tx

SIGNATURES

Staff: Signed by Richard J. Gale, PsyD, HSPP on 08/26/2019

Behavioral Health Billing

Start time: 3:15 PM
End time: 4:05 PM
Duration: 00 hours, 50 minutes
Modifier: N/A

Document generated by: Richard J. Gale, PsyD 08/26/2019 05:53 PM

Indiana Government Center South
302 W. Washington Street
Indianapolis, IN 46204

State of Indiana
Department of Correction
Division of Medical and Clinical Healthcare Services
Indiana Government Center South
302 W. Washington Street
Indianapolis, IN 46204

Facility: CIC

PATIENT:	JONATHAN RICHARDSON
DATE OF BIRTH:	[redacted]
DOC #:	127630
DATE:	08/16/2019 2:05 PM
HISTORIAN:	self
VISIT TYPE:	Onsite Consult

Individual Counsel/Psych Prog Note

General

Program Name: Outpatient

Start time: 1:10 PM

End time: 00 hours, 50 minutes

Duration: 00 hours, 50 minutes

Individuals Present/Support Resources

Contact type:
Onsite
Individual present.

MENTAL STATUS EXAM
GENERAL OBSERVATIONS:
Generally normal
Appearance:Within normal limits
Build/Stature: Within normal limits
Posture: Within normal limits
Eye Contact: Average
Activity: Within normal limits
Attitude toward examiner: Cooperative
Attitude toward parent/guardian: Not Applicable
Separation (for children/adolescent): Not applicable

MENTAL STATUS:
Unremarkable
Mood: Euthymic
Affect: Full

Speech: Clear
Thought process: Logical
Perception: WNL
Hallucination: Denied None evidenced
Thought content: Within normal limits
Delusions: None Reported
Cognition: Within normal limits
Intelligence estimate: Average
Insight: Within normal limits
Judgment: Within normal limits

Subjective Information

Individual's report of progress towards goals/objectives since last session:
Ofd. seen for individual therapy and to continue to assess claims of gender dysphoria. Offender presented history of awareness of gender, expression of gender and sexuality, and experiences in social and other interpersonal settings. Began to build a narrative of history of transgender identity.

New issues/stressors/extraordinary events presented today: None reported

Goals, Objectives, and Interventions Addressed Today

Goal Today	Objective Today
Determine whether the offender meets criteria for gender dysphoria / determine appropriate treatment	Gather history and report of past and present symptoms that may support a diagnosis of gender dysphoria

Interventions/Methods Provided:
Psychologist proceeded through an interview structured by the gender dysphoria/transgender protocol interview measuring psychosocial adjustment related to gender identity. Using this information to construct a narrative/history which can be used to help to determine whether the offender meets criteria for gender dysphoria. Agreed to meet again within the next two weeks to continue to construct this narrative.
Response to Interventions/Progress Toward Goals and Objectives:
Stable, becoming more open and comfortable talking about gender identity issues.

Current Assessment

Individual's progress: Some progress

Assessment:
Anxiety is significant. Cognitive issues are not significant. Substance abuse/dependence is not significant. Depression is significant. Impulse control is not significant. Psychotic symptoms are not significant. Suicidality is not significant. Mania/manic behavior is not significant. Patient is responding to treatment plan. The patient is compliant with the treatment plan. The patient is cooperative and communicative.

Risk Assessment

CURRENT ENCOUNTER

Risk Assessments
Patient denies suicidal ideation, plan, intent, and/or attempt.
Patient denies property damage ideation, plan, intent, and/or attempt.
Patient denies homicidal ideation, plan, intent, and/or attempt.

RISK ASSESSMENT HISTORY

Risk	Current	Past	Documented	Event Date	Approximate Date	Ideation	Plan	Intent	Scale
Suicide	Denies		08/16/2019	08/16/2019	No				
Property	Denies		08/16/2019	08/16/2019	No				
Homicide	Denies		08/16/2019	08/16/2019	No				

Attempt	Planned/ Impulsive	Drug/Alcohol Influenced	Medically Treated	Plan Attempt Description

SAFETY MANAGEMENT PLAN

No currently expressed suicidal or homicidal ideation or intent. No current need for safety plan.

Assessment/Diagnosis

AXIS IV

Severity: Moderate

Problem Type	No/Yes	Description
Primary Support Group	Yes	Very little external support
Social environment	Yes	Difficulty Trusting Others - suspicious - isolates
Legal system/crime	Yes	Incarcerated

AXIS V

Current GAF: 68

Date: 08/16/2019.

Highest GAF: 68

Date: 08/16/2019.

Plan and Additional Information

Date	Order Description
08/30/2019	MHP follow-up for Ind Tx

SIGNATURES

Staff: Signed by Richard J. Gale, PsyD, HSPP on 08/16/2019

Behavioral Health Billing

Start time: 1:10 PM
End time: 2:00 PM
Duration: 00 hours, 50 minutes
Modifier: N/A

Document generated by: Richard J. Gale, PsyD 08/16/2019 02:28 PM

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Completed By	Shannon S. McCord, LPN
Date Completed:	08/16/2019
Offender Name:	JONATHAN RICHARDSON
DOB:	[redacted]
Name of Facility:	CIC
IDOC Number:	# 127630

DISABILITY CLASSIFICATION
Disability Code: A

Section A

A. _ x _	No Disability. Offender is capable of performing activities of daily living.
B.	Offender has no useful vision even with best correction (e.g. completely blind, legally blind).
C.	Offender has a mobility of ambulatory impairment that substantially limits gross motor movement (e.g. paraplegia, stroke with hemiplegia).
D.	Offender is deaf or has profound hearing loss to an extent that the individual is unable to use hearing as a means of communication.

Date: 08/16/2019 02:23 PM
Provider: Yoko Savino MD
Document generated by: Shannon S. McCord, LPN 08/16/2019 02:23 PM

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Completed By:	Shannon S. McCord, LPN
Date Completed:	08/16/2019
Offender Name:	JONATHAN RICHARDSON
DOB:	[redacted]
Gender:	male
Name of Facility:	CIC
IDOC Number:	# 127630

FLU SCREENING FORM

In the last 24-48 hours, denies experiencing any flu symptoms.

Flu vaccine received this year CIF

Date: 08/16/2019 02:23 PM
Provider: Yoko Savino MD
Document generated by: Shannon S. McCord, LPN 08/16/2019 02:23 PM

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Shannon S. McCord, LPN

Completed By:	
Date Completed:	08/16/2019
Offender Name:	JONATHAN RICHARDSON
DOB:	[redacted]
Gender:	male
Name of Facility:	CIC
IDOC Number:	# 127630

HEAT STRESS QUESTIONNAIRE

Do you weight more than the weight indicates for your age and height on the weight table on the reverse of this form? no

Are you pregnant and in the second half of the pregnancy? no

Do you have emphysema? no

Do you have chronic obstructive lung disease? yes

Do you have congestive heart failure? no

Do you have chronic kidney disease? no

Do you have cirrhosis of the liver? no

Do you take medication to relax the urinary bladder and help control urination? no

Do you take water pills (diuretic medication)? no

Do you take ·medication to control allergies? yes

Do you take medication to control mental illness? no

Do you take medication to control the side effects of medication used to control mental illness? no

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Do you take medication to control intestinal spasm? no

Do you take any other medication that has been prescribed by a doctor? yes

Date: 08/16/2019 02:23 PM
Provider: Yoko Savino MD
Document generated by: Shannon S. McCord, LPN 08/16/2019 02:23 PM

DEPARTMENT OF CORRECTIONS
ANNUAL NURSE WELL ENCOUNTER

SITE: CIC
COMPLETED BY: Shannon S. McCord, LPN 08/16/2019 2:03 PM

State of Indiana
Department of Correction

Division of Medical and Clinical Healthcare Services
Indiana Government Center South
302 W. Washington Street
Indianapolis, IN 46204

Facility: CIC

PATIENT:	JONATHAN RICHARDSON
DATE OF BIRTH:	[redacted]
DOC #:	127630
DATE:	08/16/2019 2:03 PM
VISIT TYPE:	Nurse Visit

Vital Signs

Height

Time	ft	in	cm	Last Measured	Height Position
2:03 PM	5.0	11.0	0.0	02/08/2014	0

Weight/BSA/BMI

Time	lb	oz	kg	Context	BMI kg/m2	BSA m2
2:03 PM	187.0		84.822	dressed with shoes	26.08	

Blood Pressure

Time	BP mm/Hg	Position	Side	Site	Method	Cuff Size
2:03 PM	112/70	sitting	left	arm	manual	adult

Temperature/Pulse/Respiration

Time	Temp F	Temp C	Temp Site	Pulse/min	Pattern	Resp/ min
2:03 PM	98.40	36.9	oral	70	regular	12

Pulse Oximetry/FIO2

Time	Pulse Ox (Rest %)	Pulse Ox (Amb %)	O2 Sat	O2 L/Min	Timing	FiO2 %	L/min	Delivery Method	Finger Probe
2:03 PM	98					21			

Measured By

Time	Measured by
2:03 PM	Shannon S. McCord, LPN

DEPARTMENT OF CORRECTIONS
ANNUAL NURSE WELL ENCOUNTER

SITE: CIC
COMPLETED BY: Shannon S. McCord, LPN 08/16/2019 2:03 PM

TB Review

Placed	Site	Side	Read	Result
07/21/2018	arm	right	07/23/2018	0 mm
07/21/2017	arm	left	07/23/2017	0 mm
07/22/2016	arm	left	07/24/2016	0 mm
05/08/2014		left	05/10/2014	0 mm
07/17/2012	arm	left	07/19/2012	0 mm
07/08/2007	RA		07/11/2007	0 mm

Past Positive Symptom Check
Reviewed and all responses negative.

Medical Observations

Tattoos/body piercing
Seen a doctor within the past 6 months
Other: wears glasses
Bruises

Physical Exam

Exam	Findings	Details
Constitutional	Normal	Well developed.
Eyes	Normal	Conjunctiva - Right: Normal, Left: Normal. Pupil - Right: Normal, Left: Normal. Fundus - Right: Normal, Left: Normal.
Ears	Normal	Inspection - Right: Normal, Left: Normal. Canal - Right: Normal, Left: Normal. TM - Right: Normal, Left: Normal. Hearing - Right: Normal, Left: Normal.
Nose/Mouth/Throat	Normal	External nose - Normal. Lips/teeth/gums - Normal. Tonsils - Normal. Oropharynx - Normal.
Neck Exam	Normal	Inspection - Normal. Palpation - Normal. Thyroid gland - Normal.
Lymph Detail	Normal	No palpable cervical, supraclavicular, or axillary adenopathy.
Respiratory	*	Auscultation - Side: bilateral, Location: diffuse, Findings: coarse breath sounds.
Respiratory	Normal	Effort - Normal.
Cardiovascular	Normal	Regular rhythm. No murmurs, gallops, or rubs.
Vascular	Normal	Pulses - Dorsalis pedis: Normal. Capillary refill - Less than 2 seconds.
Abdomen	*	Auscultation - hypoactive bowel sounds.
Abdomen	Normal	Inspection - Normal. No abdominal tenderness. No hepatic enlargement. No spleen enlargement. No hernia.
Genitourinary	Normal	No hernia.
Musculoskeletal	Normal	Visual overview of all four extremities is normal.
Extremity	Normal	No edema.
Neurological	Normal	Memory - Normal.
Psychiatric	Normal	Orientation - Oriented to time, place, person & situation. Appropriate mood and affect. Normal insight. Normal judgment.

Review/Comments

STATE000575
Exhibit 69

DEPARTMENT OF CORRECTIONS
ANNUAL NURSE WELL ENCOUNTER

SITE: CIC
COMPLETED BY: Shannon S. McCord, LPN 08/16/2019 2:03 PM

Chronic disease current
Health maintenance current
Communicable disease testing current
Medical classification current
Disability status code current
Patient smokes 20.00 packs a year
Patient has not had a 30 pack year history of smoking cigarettes
Patient stopped smoking in 2000

Comments: Denies chest pain, SOB, black or bloody stools. PPD needed but not given. Self-testicular exam info given.

Suicide Risk Screening

1. Arresting or transporting officer believes subject may be suicide risk. No
2. Lacks close family/friends in community. No
3. Experienced a significant loss within last 6 months (loss of job, relationship, death of close family member). Yes
4. Worried about major problems other than legal situation (terminal illness). No
5. Family member or significant other has attempted or committed suicide (spouse, parent, sibling, close friend, and lover). No
6. Has psychiatric history (psychotropic medication or treatment). Yes
7. Holds position of respect in community (i.e., professional, public official) and/or alleged crime is shocking in nature. Expresses feelings of embarrassment/shame. No
8. Expresses thoughts about killing self. No
9. Has a suicide plan and/or suicide instrument in possession. No
10. Has previous suicide attempts. (Note methods and dates). Yes
11. Expresses feelings there is nothing to look forward to in the future (feelings of helplessness and hopelessness). No
12. Shows signs of depression (crying, emotional flatness). No
13. Appears overly anxious, afraid or angry. No
14. Appears to feel unusually embarrassed or ashamed. No

DEPARTMENT OF CORRECTIONS
ANNUAL NURSE WELL ENCOUNTER

SITE: CIC
COMPLETED BY: Shannon S. McCord, LPN 08/16/2019 2:03 PM

15. Is acting and/or talking in a strange manner. Cannot focus attention; hearing or seeing things not there). No

16. History of substance abuse treatment? No

17. Is apparently under the influence of alcohol or drugs. No

18. If YES to #17, is individual incoherent or showing signs of withdrawal or mental illness. No

Total Yes's: 3

Comments:
Sister died of heroin dose- 4-5 months ago. Brother died after from methamphetamine. Has 4-5 previous suicide attempts.

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Division of Medical and Clinical Healthcare Services
Indiana Government Center South
302 W. Washington Street
Indianapolis, IN 46204

Completed By:	Shannon S. McCord, LPN
Date Completed:	08/16/2019
Offender Name:	JONATHAN RICHARDSON
DOB:	[redacted]
Gender:	male
Name of Facility:	CIC
IDOC Number:	# 127630

MEDICAL STATUS CLASSIFICATION

Medical Code: G2

A.	Free of illness or injury; free of physical impairment; individuals with short term self-limiting condition requiring minimal surgical, medical, nursing or dental intervention limited to 30 days duration.
B.	Illnesses that do or will recurrently require skilled nursing care of any chronic physical or cognitive disability which requires on-going nursing care. Needs inpatient bed or immediate access to an inpatient bed.
C.	Renal failure requiring hemodialysis or peritoneal dialysis.
F.	Chronic physical or medical condition requiring frequent monitoring / surveillance, the on-site availability of licensed health care personnel twenty-four hours per day, or the inmate is frail or debilitated.
G. __ x __	Any stabilized, permanent or chronic physical or medical condition in which:
1.	Frequent monitoring/surveillance is not needed.
2. __ x __	The offender demonstrates an appropriate degree of knowledge and motivation and is able to perform self-care.
3.	A twenty (20) pound or greater weight lifting restriction is needed.
4.	TB prophylactic medication is being administered.
5.	Elderly (65 years of age and above)
6.	Adolescent (younger than 18 years of age)
I.	Short term self-limiting conditions of 31 to 180 days duration: conditions which may require a placement in an observation/short stay infirmary bed or requires that an inmate be placed in a negative pressure room.
J.	Pregnancy.

Date: 08/16/2019 02:24 PM

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Provider: Yoko Savino MD
Document generated by: Shannon S. McCord, LPN 08/16/2019 02:24 PM

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302 W. Washington Street
Indianapolis, IN 46204

Facility: CIC

Date:	08/16/2019 02:03 PM
Offender Name:	JONATHAN RICHARDSON
DOB:	[redacted]
Gender:	male
DOC nbr:	# 127630

MENTAL STATUS CLASSIFICATION
BH Code: D

A. Free of mental illness
B. Psychiatric disorder that causes little functional impairment and requires infrequent psychiatric services. These services are routine in nature.
C. Psychiatric disorder that causes some functional impairment and requires frequent psychiatric and/or psychological services. These services may be routine and/or unplanned in nature and may involve mental health monitoring.
D. __ **x** __ Psychiatric disorder that causes some impairment and requires frequent psychiatric and/or psychological services and/or the individual has a history of a serious suicide attempt while in a correctional setting. Services needed may be routine and/or unplanned in nature and may involve mental health monitoring.
E. Psychiatric disorder that causes significant functional impairment such that the individual is unable to function in a standard prison environment and requires structured psychiatric and/or psychological services. Services needed are provided in a specialized mental health unit. There is a good prognosis for improvement in functional impairment and eventual movement to a less restricted environment.
F. Psychiatric disorder that causes acute or chronic extreme functional impairment such that the individual is unable to function in a standard prison environment and/or causes significant risk of harm to the individual or others around the individual and requires extensive structured psychiatric and/or psychological services. Services needed are provided in a specialized mental health unit. There may be a poor prognosis for improvement in functional impairment and eventual movement to a less restricted environment.

Date: 08/16/2019 02:25 PM
Provider: Yoko Savino MD
Document generated by: Shannon S. McCord, LPN 08/16/2019 02:25 PM

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Department of Correction
Division of Medical and Clinical Healthcare Services
Indiana Government Center South
302 W. Washington Street
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Facility: CIC

PATIENT:	JONATHAN RICHARDSON
DATE OF BIRTH:	[redacted]
DOC #:	127630
DATE:	08/05/2019 3:40 PM
HISTORIAN:	self
VISIT TYPE:	Onsite Consult

Individual Counsel/Psych Prog Note

General

Program Name: Outpatient

Start time: 3:30 PM

End time: 00 hours, 30 minutes

Duration: 00 hours, 30 minutes

Individuals Present/Support Resources

Contact type:
Onsite
Individual present.

MENTAL STATUS EXAM
GENERAL OBSERVATIONS:
Generally normal
Appearance:Within normal limits
Build/Stature: Within normal limits
Posture: Within normal limits
Eye Contact: Average
Activity: Within normal limits
Attitude toward examiner: Cooperative
Attitude toward parent/guardian: Not Applicable
Separation (for children/adolescent): Not applicable

MENTAL STATUS:
Unremarkable
Mood: Euthymic
Affect: Full

Speech: Clear
Thought process: Logical
Perception: WNL
Hallucination: Denied None evidenced
Thought content: Within normal limits
Delusions: None Reported
Cognition: Within normal limits
Intelligence estimate: Average
Insight: Within normal limits
Judgment: Within normal limits

Subjective Information

Individual's report of progress towards goals/objectives since last session:
Ofd. seen for therapy and continuation of assessment for new claims of being transgender and wanting to pursue hormone treatment. The appointment was scheduled at 2:00, but the offender claims that the medical movement letter was wrong and had the appointment scheduled at 3:00. Ofd. arrived in medical about 3:30, leaving insufficient time to complete the gender dysphoria protocol interview, but some of the offender's sexual/gender-identity history was discussed.

New issues/stressors/extraordinary events presented today: None reported

Goals, Objectives, and Interventions Addressed Today

Goal Today	Objective Today
Determine whether the offender meets criteria for gender dysphoria / determine appropriate treatment	Gather history and report of past and present symptoms that may support a diagnosis of gender dysphoria

Interventions/Methods Provided:
Psychologist listened actively, providing answers to questions posed by the offender regarding the process of being diagnosed and treated. Explored the offender's reason for the decision to "come out" at this time and explore treatment possibilities. Agreed to meet again within the next week or so to continue the discussion.
Response to Interventions/Progress Toward Goals and Objectives:
Engaged, open, slightly defensive and skeptical of the psychologist's support/stance on the issue.

Current Assessment

Individual's progress: Some progress

Assessment:
Anxiety is not significant. Cognitive issues are not significant. Substance abuse/dependence is not significant. Depression is significant. Impulse control is not significant. Psychotic symptoms are not significant. Suicidality is not significant. Mania/manic behavior is not significant. Patient is responding to treatment plan. The patient is compliant with the treatment plan. The patient is cooperative and communicative.

Risk Assessment

CURRENT ENCOUNTER

Risk Assessments
Patient denies suicidal ideation, plan, intent, and/or attempt.
Patient denies property damage ideation, plan, intent, and/or attempt.
Patient denies homicidal ideation, plan, intent, and/or attempt.

RISK ASSESSMENT HISTORY

Risk	Current	Past	Documented	Event Date	Approximate Date	Ideation	Plan	Intent	Scale
Suicide	Denies		08/05/2019	08/05/2019	No				
Property	Denies		08/05/2019	08/05/2019	No				
Homicide	Denies		08/05/2019	08/05/2019	No				

Attempt	Planned/ Impulsive	Drug/Alcohol Influenced	Medically Treated	Plan Attempt Description

SAFETY MANAGEMENT PLAN

No currently expressed suicidal or homicidal ideation or intent. No current need for safety plan.

Assessment/Diagnosis

AXIS IV

Severity: Moderate

Problem Type	No/Yes	Description
Primary Support Group	Yes	Very little external support
Social environment	Yes	Difficulty Trusting Others - suspicious - isolates
Legal system/crime	Yes	Incarcerated

AXIS V

Current GAF: 65

Date: 08/05/2019.

Highest GAF: 68

Date: 03/07/2019.

Plan and Additional Information

Date	Order Description
08/12/2019	MHP follow-up for Continue GD eval

SIGNATURES

Staff: Signed by Richard J. Gale, PsyD, HSPP on 08/05/2019

Behavioral Health Billing

Start time: 3:30 PM
End time: 4:00 PM
Duration: 00 hours, 30 minutes
Modifier: N/A

Document generated by: Richard J. Gale, PsyD 08/05/2019 05:38 PM

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Indiana Government Center South
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Facility: CIC

PATIENT: JONATHAN RICHARDSON
DATE OF BIRTH: [redacted]
DOC #: 127630
DATE: 07/26/2019 1:36 PM
VISIT TYPE: Nurse Visit

Nurse Visit

Reason for visit: PRN breathing tx

Vital Signs

Temperature/Pulse/Respiration

Time	Temp F	Temp C	Temp Site	Pulse/min	Pattern	Resp/ min
3:09 PM				98	regular	
1:36 PM				95	regular	

Pulse Oximetry/FIO2

Time	Pulse Ox (Rest %)	Pulse Ox (Amb %)	O2 Sat	O2 L/Min	Timing	FiO2 %	L/min	Delivery Method	Finger Probe
3:09 PM	98		RA		Post-tx				
1:36 PM	98		RA		Pre-tx				

Peak Flow

Time	PeakFlow L/min	Timing	Method
3:09 PM	250	Post-tx	hand held
1:36 PM	230	Pre-tx	hand held

Comments

Time	Comments
3:09 PM	250, 250, 250.
1:36 PM	220, 210, 230.

Measured By

Time	Measured by
3:09 PM	Tamera L. Smith, RN
1:36 PM	Tamera L. Smith, RN

Nurse Protocols:
RESPIRATORY

Subjective:
Date of Onset: 07/26/2019
Previous history? Yes. Comments: asthma
Previous treatment effective? Yes.

Objective:
Lungs
Left lung:
Clear to auscultation? No.
Wheezes? Yes.

Right lung
Clear to auscultation? No.
Wheezes? Yes.

Assessment:
Alteration in health maintenance related to: asthma, .
.

Review/Comments
Patient smokes 20.00 packs a year

Medications

Medication	Sig	PRN Status	PRN Reason	Comment
albuterol sulfate 2.5 mg/3 mL (0.083 %) solution for nebulization	inhale 3 milliliter by nebulization route 2 times every day, as needed	N		
ipratropium bromide 0.02 % solution for inhalation	inhale 2.5 milliliter by inhalation route twice daily as needed, MIX WITH ALBUTEROL	N		
Pepcid 20 mg tablet	take 1 tablet by oral route 2 times every day	N		
Xopenex HFA 45 mcg/actuation aerosol inhaler	inhale 2 puff by inhalation route every 6 hours, as needed.	N		
Zocor 10 mg tablet	take 1 tablet by oral route every day in the evening	N		

Orders

Status	Order	Timeframe	Frequency	Duration	Stop Date
completed	Medication allergies reviewed, other contraindications and pregnancy ruled out prior				

	to treatment
completed	Sick call if signs and symptoms of infection develop or symptoms do not subside
completed	Patient education provided.

General Comments

PRN breathing tx administered. Pt may return to medical as needed.

Education	Date Provided	Provided By
Medication allergies reviewed, other contraindications and pregnancy ruled out prior to treatment	07/26/2019	Tamera L. Smith, RN
Patient education provided.	07/26/2019	Tamera L. Smith, RN

Document generated by: Tamera L. Smith, RN 07/26/2019 03:10 PM

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Division of Medical and Clinical Healthcare Services
Indiana Government Center South
302 W. Washington Street
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Facility: CIC

PATIENT: JONATHAN RICHARDSON
DATE OF BIRTH: [redacted]
DOC#: 127630
DATE: 07/22/2019 10:00 AM
VISIT TYPE: Onsite Consult

INDIVIDUALIZED ACTION PLAN

Program name: Outpatient
Admission date: 06/09/2016
Effective date of initial IAP:
Next review date: 01/22/2020

GOALS, OBJECTIVES AND INTERVENTIONS

Goal 3: Alleviate depressive symptoms (continued)

Target date: 01/22/2020
Adjusted target date: 09/07/2017 (Adjusted as per IAP review dated 05/01/2018)

Assessed need: Depression

Individual's strength/skills: {local.txt_stengths}

Potential barriers: {local.txt_barriers}

- Objective 1: Identifies negative thinking supporting depression (continued)
Start date: 06/30/2012
Target date: 01/22/2020
Adjusted target date: 09/07/2017 (Adjusted as per IAP review dated 05/01/2018)

-- Intervention 1: Individual Therapy
Frequency: q 90 days Type of provider: MHP

- Objective 2: Verbalizes increased feelings of self worth (continued)
Start date: 06/30/2012
Target date: 01/22/2020
Adjusted target date: 09/07/2017 (Adjusted as per IAP review dated 03/07/2017)

-- Intervention 2: Individual Therapy
Frequency: q 90 days Type of provider: MHP

Goal 4: Determine whether the offender meets criteria for gender dysphoria / determine appropriate treatment (new)

Start date: 07/22/2019
Target date: 10/22/2019

Assessed need: Evaluation for gender dysphoria

Individual's strength/skills: {local.txt_stengths}

Potential barriers: {local.txt_barriers}

- Objective 1: Gather history and report of past and present symptoms that may support a diagnosis of gender dysphoria (new)
Start date: 07/22/2019
Target date: 10/22/2019
Adjusted target date: (Adjusted as per IAP review dated 05/01/2018)

-- Intervention 1: Gender Dysphoria Evaluation and, if appropriate, staffing with multidisciplinary team to determine whether a diagnosis of gender dysphoria will be made.
Frequency: monthly Type of provider: Psychologist

TRANSITION/DISCHARGE CRITERIA

Individual has participated in the development of this plan:
Yes

Others participated in the development of this plan:
No

SIGNATURES

Staff: Signed by Richard J. Gale, PsyD, HSPP on 07/26/2019

Document generated by: Richard J. Gale, PsyD 07/26/2019 09:22 AM

Indiana Government Center South
302 W. Washington Street
Indianapolis, IN 46204

State of Indiana
Department of Correction
Division of Medical and Clinical Healthcare Services
Indiana Government Center South
302 W. Washington Street
Indianapolis, IN 46204

Facility: CIC

PATIENT:	JONATHAN RICHARDSON
DATE OF BIRTH:	[redacted]
DOC #:	127630
DATE:	07/22/2019 10:00 AM
HISTORIAN:	self
VISIT TYPE:	Onsite Consult

Individual Counsel/Psych Prog Note

General

Program Name: Outpatient

Start time: 10:00 AM

End time: 00 hours, 35 minutes

Duration: 00 hours, 35 minutes

Individuals Present/Support Resources

Contact type:
Onsite
Individual present.

MENTAL STATUS EXAM
GENERAL OBSERVATIONS:
Generally normal
Appearance:Within normal limits
Build/Stature: Within normal limits
Posture: Within normal limits
Eye Contact: Average
Activity: Within normal limits
Attitude toward examiner: Cooperative
Attitude toward parent/guardian: Not Applicable
Separation (for children/adolescent): Not applicable

MENTAL STATUS:
Unremarkable
Mood: Euthymic
Affect: Full

Speech: Clear
Thought process: Logical
Perception: WNL
Hallucination: Denied None evidenced
Thought content: Within normal limits
Delusions: None Reported
Cognition: Within normal limits
Intelligence estimate: Average
Insight: Within normal limits
Judgment: Within normal limits

Subjective Information

Individual's report of progress towards goals/objectives since last session:
Ofd. seen for scheduled follow-up therapy. He came with a health care request in hand, #127630, dated today but not screened by nursing because it had not been turned in. He says "I would like to request estrogen treatments, for my transgender needs." He claims that he has felt for a long time as if he is not in the right body, and he claims to have aluded to this and considered revealing it multiple times over the recent past. (continued below)

New issues/stressors/extraordinary events presented today: New issue, CA/IAP update required

Explanation: He pointed to his tattoos of women around his face and arms, saying that this is evidence of his feminine identity. He also shaved his face for the first time in years before this appointment, again by his report related to his transgender identity. Although his initial report was unclear regarding when he first began to identify as a transwoman, he indicates that it goes back some time. He claims that his eventual goal is full transition, including sexual reassignment surgery. He believes that engaging in this transition will help him to cope with the discomfort and distress that he has experienced as a result of having to keep this identity secret.

Goals, Objectives, and Interventions Addressed Today

Goal Today	Objective Today
Determine whether the offender meets criteria for gender dysphoria / determine appropriate treatment	Gather history and report of past and present symptoms that may support a diagnosis of gender dysphoria

Interventions/Methods Provided:
Psychologist listened actively to the offender's concerns regarding transgender identity and his wish to begin the process of transitioning. Explored questions with the offender regarding the timing of this revelation, his perceptions of how things may change for him if treatment for gender dysphoria is started, and his long term goals and ideas. Educated the offender about the process of gender dysphoria evaluation and treatment through IDOC in order to set appropriate expectations.
Response to Interventions/Progress Toward Goals and Objectives:
Offender appeared comfortable and confident expressing transgender identity and the desire to begin to transition to life as a woman.

Current Assessment

Individual's progress: Some progress

Assessment:
Anxiety is not significant. Cognitive issues are not significant. Substance abuse/dependence is not significant. Depression is not significant. Impulse control is not significant. Psychotic symptoms are not significant. Suicidality is not significant. Mania/manic behavior is not significant. Patient is responding to treatment plan. The patient is compliant with the treatment plan. The patient is cooperative and communicative.

Risk Assessment

CURRENT ENCOUNTER

Risk Assessments

Patient denies suicidal ideation, plan, intent, and/or attempt.
Patient denies property damage ideation, plan, intent, and/or attempt.
Patient denies homicidal ideation, plan, intent, and/or attempt.

RISK ASSESSMENT HISTORY

Risk	Current	Past	Documented	Event Date	Approximate Date	Ideation	Plan	Intent	Scale
Suicide	Denies		07/22/2019	07/22/2019	No				
Property	Denies		07/22/2019	07/22/2019	No				
Homicide	Denies		07/22/2019	07/22/2019	No				

Attempt	Planned/ Impulsive	Drug/Alcohol Influenced	Medically Treated	Plan Attempt Description

SAFETY MANAGEMENT PLAN
No currently expressed suicidal or homicidal ideation or intent. No current need for safety plan.

Assessment/Diagnosis

AXIS IV
Severity: Moderate

Problem Type	No/Yes	Description
Primary Support Group	Yes	Very little external support
Social environment	Yes	Difficulty Trusting Others - suspicious - isolates
Legal system/crime	Yes	Incarcerated

AXIS V
Current GAF: 65
Date: 07/22/2019.

Highest GAF: 68
Date: 03/07/2019.

Plan and Additional Information

Date	Order Description
07/29/2019	MHP follow-up for Ind Tx / GD Eval

Plan/Additional Information:
Will continue to meet with offender to gather additional information regarding the duration of transgender identity, the challenges and difficulties, both internal and external, that this issue has caused, and to determime whether a diagnosis of gender dysphoria appears appropriate and treatment is indicated.

SIGNATURES

Staff: Signed by Richard J. Gale, PsyD, HSPP on 07/26/2019

Behavioral Health Billing

Start time:	10:00 AM
End time:	10:35 AM
Duration:	00 hours, 35 minutes
Modifier:	N/A

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302 W. Washington Street
Indianapolis, IN 46204